BACKWARD DISPLACEMENT OF THE UTERUS.*

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It may seem presumptuous to attempt to offer something new on retro-displacement of the uterus as so much has previously, and that recently, been said on the subject. Nevertheless I will offer a few ideas regarding the mechanic and orthopedic factors appertaining to treatment. Papers by Stumdorf, Dickerson, Noble, Goffe, and others, have in part furnished material for this paper.

Regarding the uterus as an organ suspended by ligaments, supported indirectly by the pelvic floor, and having its attachment principally at the cervix, leaving the fundus freely movable, we have much opportunity for normal variations as to location.

Should woman walk horizontally, or on all fours, there would be no need for this discussion. However she persists in assuming the upright position for about two-thirds of the twenty-four hours, and thus produces troubles that have closely proximated the social bug in furnishing livelihood for gynecologists.

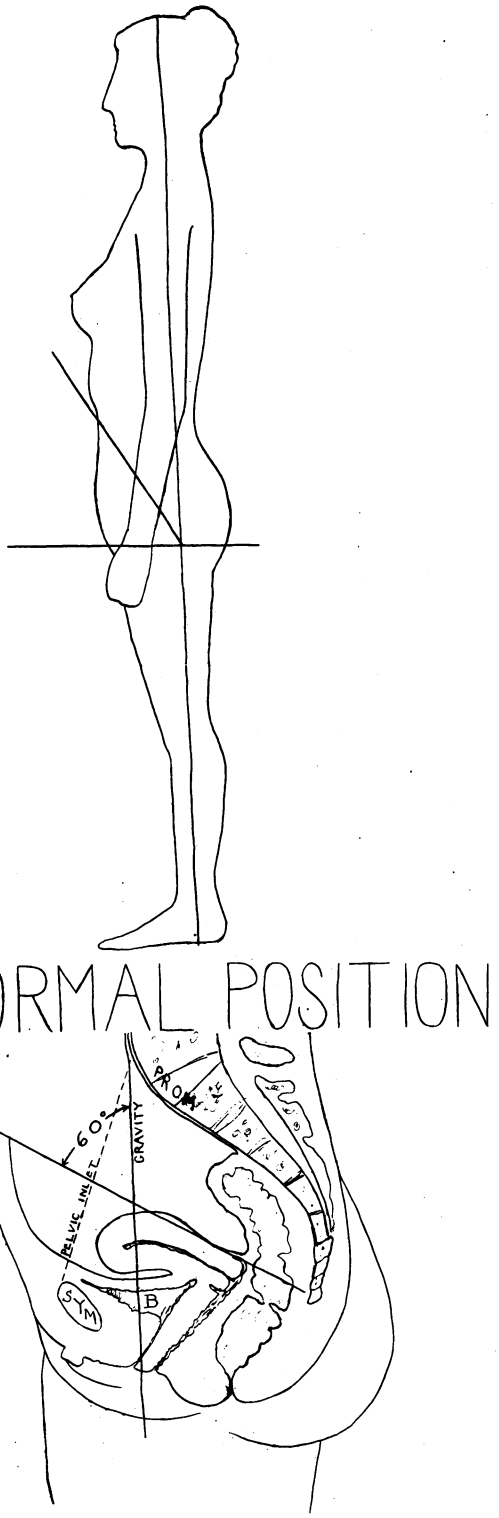
I have prepared charts to explain some of my ideas. You will observe from chart 1 that the angle of deflection of the abdominal cavity and its eddy, the pelvic cavity, is about 60°; also that a perpendicular or gravity line touching the promontory strikes the back of the symphysis.

Charts 2 and 3 show figures designated "Military" and "Slouch," which show by lines the variations of angulation of the two cavities, also the gravity lines.

In the "Military," it is seen that the sacrum forms a roof to the pelvic cavity, while in the "Slouch," it is the rear wall. Now this has two distinct effects on the location of the fundus of the uterus. First, in that the utero-sacrals either suspend the cervix in the "Military," or pulls more decidedly backward in the "Slouch." Second, Intra-abdominal pressure is deflected in the "Military" but strikes almost directly into the pelvic in "Slouch." Obviously, if all other things are equal the "Slouch" will have the uterus forced into the inviting hollow of the sacrum by direct intra-abdominal pressure and be pulled back by ligaments. While in the "Military" the uterus will fall forward and what intra-abdominal pressure affects it will be spent on the rear of the fundus to hold it toward the bladder.

The guy ropes (round ligaments) are a decided factor in holding the fundus forward, so that the intra-abdominal pressure falls on the rear of fundus.

Resultant pathology from mal-position is often the condition for which treatment is sought and the backward displacement per se, may play a minor part in the symptom-complex. This pathol-



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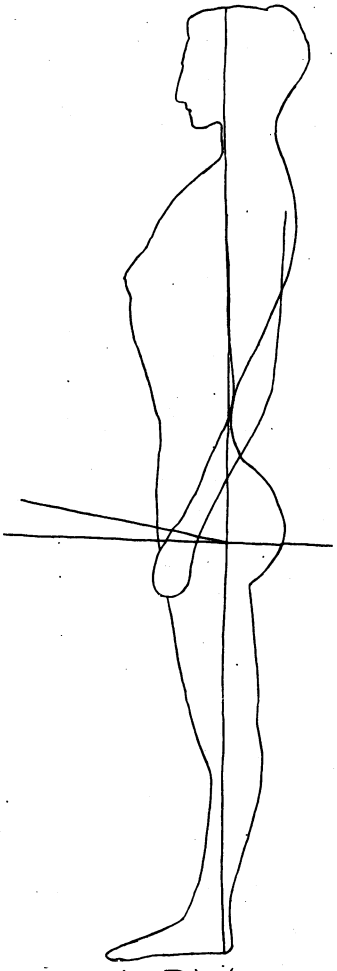
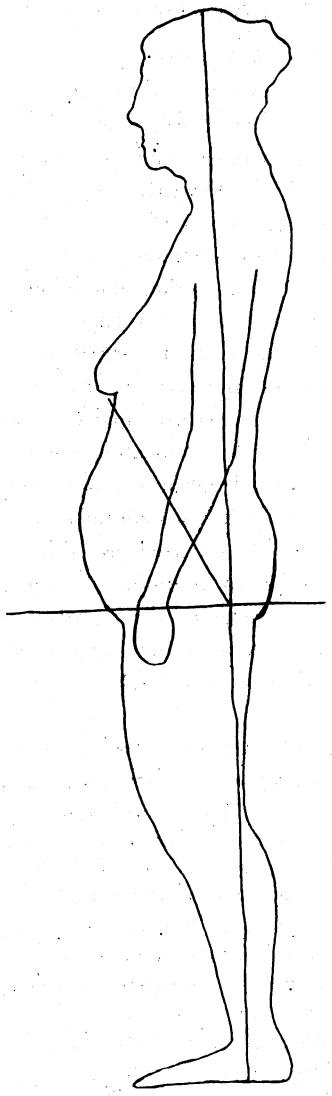
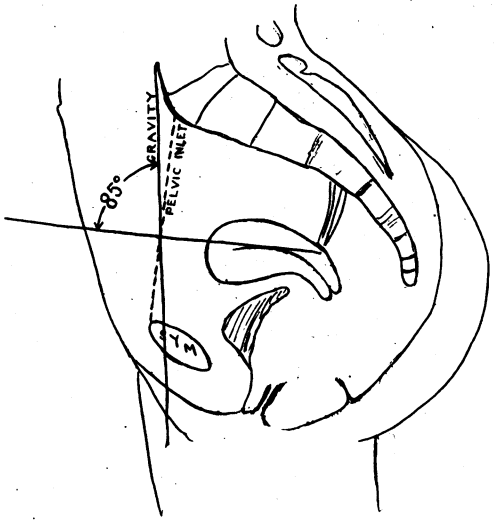
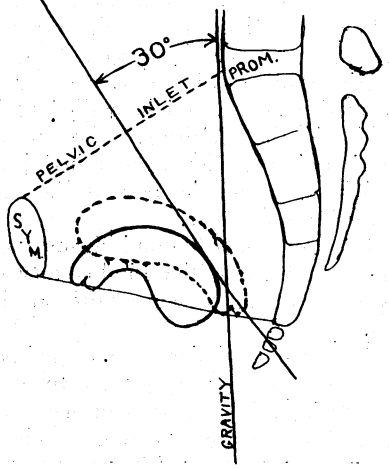


MILITARY



SLOUCH





ogy may therefore become the condition of first importance in the question of treatment, and the retro-displacement the secondary. When a backward displacement exists and symptoms seem to be due to this, especially if neurasthenia is a prominent symptom, the question as to whether surgery is indicated is a master problem. If no other disease can be found in the pelvis, we should make exhaustive study and consider long before we advise surgery, for the end results may be disappointing. If radical treatment is deemed necessary, I do not know of any operation in the whole domain of surgery where surgical judgment is of greater importance in wisely selecting the particular operation best suited to the individual case.

There was a time when the variety of pickles and of operations for retro-displacements were about numerically equal, but Mr. Heinz has been out-distanced in the race, as we have more than 100 variations of the operation for retro-displacement, and to be able to select the proper procedure is often of more value to the patient than to be able to perfectly execute a technique that is not applicable to the condition found. For example: If the cervix is held far to the front by a pronounced Goff ligament or congenitally located near pubes, and a Baldy-Webster only is done, we'd make bad matters worse by producing an anti-flexion, at the same time crowding the whole uterus over on the bladder. In such a case vaginal work may be necessary to let the cervix backward by cutting the ligament of Goff, and probably the utero-sacrals shortened to hold cervix back and then the fundus falls forward and is kept so by intra-abdominal pressure; or it may be necessary to do some round ligament shortening to tilt the fundus to the front. Another illustration: When the cervix is held well back and no pathology exists in the adnexa and simply bringing the fundus forward is the only need, I think the Baldy-Webster the most ideal procedure. There are other cases where Olshausen may be the ideal and therefore the best operation. Many things, however, should be considered and each case must be individualized from many standpoints to get a satisfactory result. Pages could be written in the discussion of factors governing the proper selection or variation of operations. However, we are impressed that surgery and surgery alone is not always the proper manner of dealing with this class of troubles.

The pessary which is becoming obsolete in Gynecology may have a place in this condition, especially in this orthopedic or improper skeletal poise. A Smith Hodge or some similar make may be properly fitted out and be found useful. I consider the pessary of value in that it fills the space in the hollow of sacrum that holds the fundus; it also pushes up the utero-sacrals, taking up their slack and in that way pulls the cervix back, making it easier for the fundus to tilt forward, thus allowing the intestines and intra-abdominal pressure to hold it forward. If the pessary is used temporarily during gymnastic exercises, along with a properly adjusted corset, and if it be subject to constant supervision, every effort being made to obtain a correct skeletal poise, we may get much benefit from its use and later dispense with it altogether. The principal object in all these cases should therefore be to secure a normal anatomic position within the pelvis; proper poise of the lower abdomen and pelvic planes, and to decrease the lower abdominal space and increase the upper abdominal area. In this way we are preventing general ptoses, of which backward uterine displacement is often only one of many.

Our main object in all these cases should be to secure and maintain normal anatomic relations of the pelvis and abdominal and pelvic contents.

The women who have congenital poor poise and bad placement of organs, also the women who from lack of attention to their position have failed to develop a proper normal anatomical corset, i. e., a good firm anterior wall, are the ones that have this condition. We must *reform* them and must see that they develop enough muscle tone and correct skeletal poise to prevent the ptosis and backache and neurasthemia that most of these women come to us for. It requires a master effort not to operate and then let the other doctor have the patient back to do with as he may. It may be necessary to put these women to bed and in the Trendelenberg position at first to get the abdominal contents into upper abdomen and while in bed assist the development of good abdominal wall tone by proper exercises, also put on some fat which will help to deflect intra-abdominal pressure and form a shelf to support the kidneys and other abdominal contents. The knee-chest, or easier, swinging the body from the thighs in prone position, relaxing and expanding the upper abdomen and then contracting the lower abdominal wall to develop better tone and also push up the contents. After the period of rest and treatment in bed, when it is necessary, the patient should be properly and comfortably fitted with some mechanical supports, such as braces, binders or scientifically adjusted corsets; she should be under constant supervision for a long period of time, faithfully instructed as to exercises and proper posture, emphasizing the importance of not stooping or slouching, thus preventing attitudinal strain.

The mere fact that more than 100 operations have been used for retro-displacement, brands operative treatment alone as not being successful, just as in drug therapeutics where we have a dozen remedies for one condition where drugs are not needed, as the old time dispenser believed.

But I do want to impress that gynecology does not have its limitations in what is accessible through the vagina or a four inch incision. We must and do consider what is in the pelvis, the pelvis itself, the abdominal organs, skeleton, internal secretions and, in fact, the entire woman with all the peculiarities her sex certainly produces.

The orthopedist, gastro-intestinal specialist and the gynecologist will often do well to combine their efforts on these women whose lives are miserable from the ligamentous strain, abdominal organ ptosis and the knowledge that they have "falling of the womb." Can we refrain from doing an easy, apparently harmless operation to satisfy their minds only?